STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000855	A. BUILDING: _____ B. WING _____	C 09/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEMENT HEALTH CARE CENTER	601 NORTH MORGAN BEMENT, IL 61813

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S9999	Final Observations	S9999		

STATEMENT OF LICENSURE VIOLATIONS:

300.610a)
300.1210a)
300.1210b)
300.1210d)6)
300.3240a)

Section 300.610 Resident Care Policies
a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.

Section 300.1210 General Requirements for Nursing and Personal Care
a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least

Attachment A
Statement of Licensure Violations

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S9999	Continued From page 1	S9999		

restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable.
b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.
d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:
6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These requirements are not met as evidenced by:

Based on interview and record review facility staff failed to provide supervision to prevent one resident (R1), requiring physical assistance of staff, from rolling off the bed onto the floor. This failure resulted in R1 sustaining a fracture of the fourth cervical vertebra. R1 is one of three

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S9999	Continued From page 2	S9999		

residents reviewed for falls in a sample of three.

Finding include:

The Physician's Order Sheet (POS) dated September 2015 for R1 lists the following diagnoses: Cerebral Palsy, Seizure Disorder (Grand Mal) and Profound Mental Retardation. The Minimum Data Set (MDS) dated 7/6/15 states R1 is severely cognitively impaired, requires total assistance with one staff for bed mobility and assistance of two staff for transfers with the aid of a mechanical lift. The Nursing Progress Review dated 9/2/15 documents R1 needs the assistance of two staff for bed mobility and transfers with the use of a mechanical lift. R1's care plan states "(R1) to be free from injury related to falls and (R1) has padded full side rail to be in the up position while in bed to facilitate safe care. (R1) makes random and sudden movements that place her at increased risk for falls." R1's Fall Risk Assessments dated 7/6/15 and 4/20/15 documents R1 to be High Risk for falls.

R1's Nurses Notes dated 9/13/15 at 1:15 states " Writer was called to room by CNA.(Certified Nurses Assistant) (R1) noted to be lying on floor on side. CNA stated (R1) was in bed, CNA put rail down, turned to get supplies to change (R1) and when CNA turned back around (R1) had turned to her side by grabbing bed and was falling... blood noted from side of scalp.....Physician notified with order to send to emergency room for evaluation....Ambulance arrived at 1:50 PM for transport to emergency room."

The facility's report titled "Incident Report Form-Illinois Department of Public Health Notification" dated 9/13/15 stated " (E6), CNA

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S9999	Continued From page 3	S9999		

was providing care to resident while resident was in bed. CNA reached for supplies when resident rolled out of bed onto floor. CNA alerted (E7) LPN (Licensed Practical Nurse) who noted (R1) on left side with laceration to scalp.....Physician notified with order received to send to emergency room for evaluation.....(R1) returned from emergency room at 5:45 PM with 3 staples to laceration on the scalp and fracture of fourth cervical vertebra...."

R1's hospital records titled Diagnostic Imaging dated 9/13/15 at 2:19 PM documents under "Impression: 1. C4 (fourth cervical) anterior vertebral body fracture with fracture extending through the adjacent anterior osteophyte..."

R1's Emergency Department Report dated 9/13/15 documents under "Present Illness- (R1) is a 59 year old Female who presents to the emergency department after rolling out of bed at the Nursing Home. Discharge Impression: Laceration of scalp, Fracture of fourth cervical vertebra, Fall from bed."

E6, stated on 9/18/15 at 2:16 PM " I was changing (R1) and (R1) was in the bed and the bed rail was down. I realized I did not have her clean brief so I turned around to pick up the clean brief and heard (R1) starting to roll out of bed. I tried to catch her to ease the fall but was unable to. (R1) was on the edge of the bed and the bed rail was down and I did turn away...I told the nurse immediately."

E1, Administrator confirmed E6 did turn away from R1 and R1 rolled out of bed and sustained a fracture and scalp laceration.

The facility's undated policy titled "Fall

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S9999	Continued From page 4 Prevention" states "All staff to provide for resident safety and to minimize injuries related to falls...established a visual alert system to check those at risk." (B) ********** Section 300.690 b)c) Incidents and Accident b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence. This requirement is not met as evidenced by: Based on interview and record review the facility failed to report a fall incident with injuries requiring hospital intervention for R2, one of three residents reviewed for falls in a sample of three. Findings include: The Physician's Order Sheet (POS) for R2 lists the following diagnoses: Dementia, Asthma, and	S9999		

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Osteoporosis. The same POS documents R2 is to be up with assistance as tolerated and to be transferred by a mechanical lift. The Minimum Data Set (MDS) dated 3/30/15 states R2 needs extensive assistance with two staff for all transfers. The MDS continues to document R2 is severely cognitively impaired. R2's Fall Risk Assessment dated 1/5/15 and 3/30/15 documents R2 to be high risk for falls.

R2's Nurses Notes dated 4/20/15 at 10:35 AM documents " At 10:30 (E8) Dietary Manager notified writer of (R2) observed on floor in resident room. When writer went to (R2)'s room E2, Director of Nurses and E1 Administrator were in the room with (R2) with two CNA(Certified Nurses Assistance). (R2) was observed on the floor on right side of body, face down and lying on right arm. Blood was noted on the floor nest to (R2's) head...Laceration noted to right temporal area and skin tear to right hand between 4th and 5th digits...10:40 AM Ambulance called for transport to emergency room. 11:05 AM Ambulance left facility with (R2) to emergency department." Nurses Notes 4/20/15 at 2:10 PM documents " (R2) returned to facility via ambulance - no new orders received"

R2's Physician's Progress Note dated 4/21/15 states " (R2) tipped his entire wheelchair over and had a contusion of his right forehead and his right hand..... (R2) did fall on the 20th of April at 10:20 AM and was sent to the Emergency Department and evaluated there."

E1, Administrator stated on 9/22/15 at 10:45 AM " I did not report this incident to IDPH (Illinois Department of Public Health) because there was no major injury to (R2) . (R2) only had a contusion and skin tear. I thought I had to report major injuries only like sutures and fractures."

(B)